AMERICAN FAMILY MUTUAL INSURANCE COMPANY

6000 American Parkway
Madison, WI 53783-0001

NAIC COMPANY CODE 19275

LIMITED MARKET CONDUCT EXAMINATION REPORT

As of December 31, 2004

PREPARED BY INDEPENDENT CONTRACTORS FOR THE COLORADO DEPARTMENT OF REGULATORY AGENCIES DIVISION OF INSURANCE

AMERICAN FAMILY MUTUAL INSURANCE COMPANY
6000 American Parkway
Madison, WI 53783-0001

MARKET CONDUCT EXAMINATION REPORT
As of
December 31, 2004

Prepared by

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Independent Contract Examiners

November 17, 2006

David F. Rivera
Commissioner of Insurance
State of Colorado
1560 Broadway Suite 850
Denver, Colorado 80202

Commissioner Rivera:

In accordance with §§ 10-1-203 and 10-3-1106, C.R.S., a limited market conduct examination of the private passenger automobile insurance claims and complaint handling practices of American Family Mutual Insurance Company has been conducted.

The Company's claims records were examined at 9510 Meridian Blvd., Englewood, CO 80112.

The examination covered the period from July 1, 2003 to December 31, 2004.

A report of the limited claims and complaint market conduct examination of American Family Mutual Insurance Company is, herewith, respectfully submitted.

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MARKET CONDUCT
EXAMINATION REPORT
OF
AMERICAN FAMILY MUTUAL INSURANCE COMPANY

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COMPANY PROFILE

American Family Mutual Insurance Company (hereinafter referred to as the Company) was founded on October 3, 1927, in Madison, Wisconsin, and began doing business under the name Farmer's Mutual Insurance Company. This name was changed to the present name in 1963. The Company began marketing private passenger automobile insurance in the State of Colorado in 1966.

The Company is a multi-line insurance provider with a wide variety of products available for individuals and businesses. Insurance products are presently written in seventeen (17) states. Additionally, the Company has secured licenses, but is not actively writing insurance products in five (5) other states.

The Company bases its Colorado sales and services on a network of exclusive agents and employees located in communities throughout the state. The Company's regional claims office for Colorado is located at 9510 Meridian Blvd., Englewood, CO 80112.

*As of December 31, 2004 the Company had reported premium in Colorado of $220,179,000 for private passenger automobile insurance, representing a 7.82% market share.

*Data as reported in the 2004 Colorado Insurance Industry Statistical Report.

PURPOSE AND SCOPE OF EXAMINATION

This market conduct examination report was prepared by independent examiners contracting with the Colorado Division of Insurance (Division) for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the State of Colorado. This procedure is in accordance with Colorado insurance law, §10-1-204(6), C.R.S., which empowers the Commissioner to supplement the Division's resources to conduct market conduct examinations. The findings in this report, including all work products developed in the production of this report, are the sole property of the Division.

The purpose of the examination was to determine the Company's compliance with Colorado insurance laws related to private passenger automobile insurance claims and complaint handling practices. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

This examination was governed by, and performed in accordance with, procedures developed by the National Association of Insurance Commissioners and the Division. In reviewing material for this report the examiners relied primarily on records and material maintained and/or submitted by the Company. The examination covered an eighteen (18) month period of the Company's operations, from July 1, 2003 to December 31, 2004.

File sampling was based on a review of claim files that were systematically selected using ACL™ software and computer data files provided by the company. Sample sizes were chosen based on procedures developed by the National Association of Insurance Commissioners. Upon review of each file any concerns or discrepancies were noted on comment forms and delivered to the Company for review. Once the Company was advised of a finding contained in a comment form, the Company had the opportunity to respond. For each finding the Company was requested to agree, disagree or otherwise justify the Company's noted action. The examination report is a report by exception. Therefore, much of the material reviewed is not addressed in this written report. Reference to any practices, procedures, or files, which manifested no improprieties, was omitted.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

The report addresses private passenger automobile insurance business and contains information regarding exceptions to Colorado insurance laws. The examination was limited to review of claims and complaint handling practices only.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Commissioner. Failure to identify or criticize specific Company practices does not constitute acceptance by the Division. Examination findings may result in administrative action by the Division.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's private passenger automobile claims and complaint handling practices to determine compliance with the Colorado insurance laws as outlined in Exhibit 1.

Exhibit 1

Laws	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts – immunity for furnishing information relating to suspected insurance fraud – legislative declaration.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-4-404.5, C.R.S.	Rating plans – property and casualty type II insurers – rules.
Section 10-4-413, C.R.S.	Records required to be maintained.
Section 10-4-609, C.R.S.	Insurance protection against uninsured motorists – applicability.
Section 10-4-610, C.R.S.	Property damage protection against uninsured motorists.
Section 10-4-611, C.R.S.	Elimination of discounts – damage by uninsured motorist.
Section 10-4-613, C.R.S.	Glass repair and replacement.
Section 10-4-614, C.R.S.	Inflatable restraint systems - replacement - verification of claims.
Section 10-4-633, C.R.S.	Certification of policy and notice forms.
Section 10-4-634, C.R.S.	Assignment of payment for covered benefits.
Section 10-4-639, C.R.S.	Claims practices for property damage.
Section 10-4-706, C.R.S.	Required coverages-complying policies- PIP examination program.
Section 10-4-706.5, C.R.S.	Operator's policy of insurance.
Section 10-4-707, C.R.S.	Benefits-how payable.
Section 10-4-708, C.R.S.	Prompt payment of direct benefits.
Section 10-4-713, C.R.S.	No tort recovery for direct benefits.
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Insurance Regulation 5-1-2	Application and Binder Forms
Insurance Regulation 5-1-10	Rate and Rule Filing Submissions Property and Casualty Insurance
Insurance Regulation 5-2-1	Relative Value Schedule for No Fault
Insurance Regulation 5-2-2	Renewal of Automobile Insurance Policies – Excluded Named Drivers
Insurance Regulation 5-2-3	Concerning Automobile Insurance Policies Issued or Renewed Prior to July 1, 2003
Insurance Regulation 5-2-6	Automobile No Fault Cost Containment Options
Insurance Regulation 5-2-8	Timely Payment of Personal Injury Protection Benefits
Insurance Regulation 5-2-9	Personal Injury Protection Examination Program
Insurance Regulation 5-2-11	Transition from No-Fault Auto to Tort System
Insurance Regulation 5-2-12	Concerning Automobile Insurance Consumer Protections
Insurance Regulation 5-2-15	Concerning Consumer Protection for Vehicle Valuation and Rental Reimbursements
Insurance Regulation 6-1-1	Limiting coverage
Insurance Regulation 6-2-1	Complaint Record Maintenance

Complaints

The examiners compared the Division's complaint log against the Company's log to determine if the logs were consistent and to review complaint activity and trends. A sample of complaints was reviewed and all complaints appeared to have been handled in a timely manner.

Claims

For the period under examination, the examiners systematically selected the following samples to determine compliance with claims handling practices.

Review Lists	Population	Sample Size	Percentage to Population
Collision Claims Paid	8,608	100	1%
Total Loss Claims Paid	2,626	50	2%
Auto Claims Paid - PIP	708	100	14%
Auto Claims – Closed Without Payment	10,472	100	< 1%
Auto Medical Claims Paid	1,647	50	3%

For the period under examination, a sample of files categorized as "medical service referral form" claim files was initially selected by Division personnel from a listing provided by the Company. On August 3, 2006, it was determined that the Company had erroneously sorted one column in the list containing the "reason for referral" codes, which resulted in numerous errors in the "reason for referral" classification. A corrected listing was provided to the Division on August 4, 2006, and any of the files that had already been provided and were in the correct categories were reviewed. In the instances in which the sample size required more files, additional files were selected from the corrected list to complete the sample size.

The six referral reason categories that were reviewed were as follows:

"MI" – This category refers to Mitchell Medical, a bill review program that was used on non-PPO claims to process the usual and customary charges of a billing. An "MI" referral was made to medical services by the adjuster when they had a question regarding the "end note" generated from the system.

"LF" – This category refers to any referral from legal.

"CO" – This category refers to consultant reviews that may have been requested for the following reasons:

1) Specialty area of the treatment or issue beyond the medical services nurse expertise;
2) Questions surrounding impairment;
3) Questions surrounding relatedness and complex injuries;
4) Questions surrounding experimental treatment; and
5) Questions surrounding appropriateness and necessity of treatment.

"IME" – This category refers to independent medical examinations (IME) – set-up only. An adjuster requested an IME or consultant review set-up only for claims determined to need said services. These referrals simply required medical services to review and prepare the file for the independent review to include clipping pertinent documents for copying and drafting the questions to be answered by the independent physician. No further activity was required by medical services on set-up only referrals.

"UN" – This category refers to unnecessary services/inappropriate services.

"UR" – This category refers to services unrelated to covered injury/illness.

Review Lists	Population	Sample Size	Percentage to Population
"MI" Category	60	10	17%
"LF" Category	4	4	100%
"CO" Category	3	3	100%
"IME" Category	592	49	8%
"UN" Category	1,106	50	5%
"UR" Category	569	50	9%

EXAMINATION REPORT SUMMARY

The examination resulted in three (3) issues arising from the Company's apparent failure to comply with Colorado insurance laws that govern all property and casualty insurers operating in Colorado.

Claims Practices:

In the area of claim practices, three (3) compliance issues are addressed in this report.

In PIP claim files where there was a wage loss benefit, wage information and supporting documentation was recalculated using the formula as prescribed under Colorado insurance laws, tested to the Company's own calculations and traced directly to actual payments with no errors noted. All wage loss payments were timely and paid according to policy provisions and Colorado insurance laws. In addition, the examination procedures included the review of PIP claim files and the process that the Company followed in evaluating the length as well as course of treatment to qualified injured parties. Through this examination relating to the closing of the PIP portion of claims, the Company appeared to be in compliance with Colorado insurance laws. It did not appear that Company personnel arbitrarily suspended PIP benefits, but ordered either independent medical examinations (IME) or preferred provider organization medical examinations (PPO-ME) to evaluate whether the injuries were related to the automobile accident as well as the appropriateness and length of treatment and other claim-related factors. It appears that the Company is in compliance with Colorado insurance laws with respect to its handling of these medical examinations.

The issues in this phase were identified as follows:

- **Failure, in some cases, to comply with Colorado insurance law regarding the subrogation of PIP claims.**

- **Failure, in some cases, to pay PIP claims within the required time period.**

- **Failure, in some cases, to pay title and transfer fees on total loss claims.**

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Division. Results of previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

AMERICAN FAMILY MUTUAL INSURANCE COMPANY

PERTINENT FACTUAL FINDINGS

CLAIMS PRACTICES

Issue A: Failure, in some cases, to comply with Colorado insurance law regarding the subrogation of PIP claims.

Section 10-4-713, C.R.S., No tort recovery for direct benefits states in part:

> (1) Neither any person eligible for direct benefits described in section 10-4-706 (1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3) nor any insurer providing benefits described in section 10-4-706 (1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3) shall have any right to recover against an owner, user, or operator of a motor vehicle or against any person or organization legally responsible for the acts or omissions of such person in any action for damages for benefits required to be paid under section 10-4-706 (1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3), regardless of any deductible option, waiting period, or percentage limitation; except that an insurer paying benefits under section 10-4-706 (1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3) to or for any one person for whose injuries legal liability exists or may exist on the part of a third person who is not an insured under a policy of automobile liability insurance issued by an insurer licensed to write automobile liability insurance in this state shall have a direct cause of action against an alleged tort-feasor to only the extent of the alleged tort-feasor's insurance coverage in excess of reasonable compensation paid to the injured person for such person's injury or damage by the alleged tort-feasor's insurer when the injured person could recover in tort pursuant to section 10-4-714. Nothing in this section shall be construed to afford such provider of benefits under section 10-4-706 (1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3) a cause of action or claim against a person to whom or for whom such benefits were paid except in those cases in which such benefits were paid by reason of fraud or material misrepresentation of fact.

In the course of the review of PIP claim files it was noted that the Company attempted, and in some cases recovered, actual PIP benefits through subrogation. The Company pursued subrogation on claims occurring after July 1, 2003, on policies written prior to July 1, 2003. Although Colorado converted from a no-fault auto system to a tort system effective for automobile insurance policies written on or after July 1, 2003, there was no automatic conversion of PIP policies issued prior to July 1, 2003, to voluntary medical coverage. Accordingly, for automobile insurance policies written prior to July 1, 2003, Colorado's auto no-fault laws, including § 10-4-713, C.R.S., apply until such policies lapse or are renewed.

Therefore, it appears the Company was not in compliance with Colorado insurance laws regarding the subrogation of PIP claims.

Recommendation Number 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-4-713, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has reviewed its subrogation procedures and implemented necessary changes in order to ensure compliance with Colorado insurance law.

Issue B: Failure, in some cases, to pay PIP claims within the required time period.

Section 10-4-708, C.R.S., Prompt payment of direct benefits, states in part:

> (1) Payment of benefits under the coverages enumerated in section 10-4-706 (1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3) shall be made on a monthly basis. Benefits for any period are overdue if not paid within thirty days after the insurer receives reasonable proof of the fact and amount of expenses incurred during that period; except that an insurer may accumulate claims for periods not exceeding one month, and benefits are not overdue if paid within fifteen days after the period of accumulation. If reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within thirty days after such proof is received by the insurer. Any part or all of the remainder of the claim that is later supported by reasonable proof is overdue if not paid within thirty days after such proof is received by the insurer. In the event that the insurer fails to pay such benefits when due, the person entitled to such benefits may bring an action in contract to recover the same.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> (VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

Colorado Insurance Regulation 5-2-8, Timely Payment of Personal Injury Protection Benefits, jointly promulgated by the Commissioner of Insurance and the Executive Director of the Department of Revenue pursuant to §§10-1-109, 10-4-704, 10-4-708(1.3) (effective until July 1, 2003 except for claims incurred under policies lawfully in effect as described in this regulation), and 10-3-1110(1), C.R.S., states in part:

Section 3. Applicability and Scope

> The Colorado Reparations (No-Fault) Act was repealed effective July 1, 2003. Automobile insurance policies with personal injury protection (PIP) benefits issued or renewed prior to July 1, 2003 will continue to incur PIP claims until such benefits do not apply any longer. This regulation applies to claims occurring under No-Fault Policies issued prior to July 1, 2003.

Section 4. Rule

> A. Prompt Investigation of PIP Claims

Section 10-3-1104(1)(h)(III), C.R.S., requires insurers to adopt and implement reasonable standards for the prompt investigation of claims. An insurer is also required to promptly investigate a claim while it is accumulating claim's expense.

Whenever an insurer requires that an application for benefits form be submitted by an injured party, the insurer shall forward the form to the injured party upon notification of the injury.

When an investigation is incomplete or is otherwise continued, the insurer shall, within 30 days after the documents are received as described in C. below and every 30 days thereafter, send to the claimant or the claimant's representative, and the health care provider, if applicable, a letter setting forth the reasons additional time is needed for investigation.

Where additional information is required to complete an investigation, the insurer shall request such information, specifically listing the items needed to complete the investigation. A copy of such request shall be delivered to the claimant, the claimant's representative, the health care provider or other person or entity most likely in possession of the required information.

B. Prompt Payment of Pip Benefits

Section 10-4-708(1), C.R.S. provides that benefits under the coverages enumerated in §10-4-706, C.R.S. are overdue if not paid within 30 days after the insurer receives reasonable proof of the fact and amount of the expenses incurred.

Section 10-4-708(1), C.R.S., allows for the accumulation of claims expense for periods not exceeding one month and provides that benefits are not overdue if paid within 15 after the end of a defined period of accumulation. An insurer is permitted by this statute to pay a bill within 15 days after the end of a defined accumulation period only when there is a reasonable likelihood that multiple providers are involved and more than one bill is received during the accumulation period.

The following chart illustrates the significance of error versus the population and sample examined:

Private Passenger Automobile PIP Claims Paid

Population	Sample Size	Number of Exceptions	Percentage to Sample
708	100	12	12%

An examination of 100 PIP claim files, representing 14% of all paid PIP claims handled by the Company during the examination period, showed twelve (12) exceptions (12% of the sample) wherein the Company failed to pay at least one medical bill in each file within the thirty (30) day statutory standard as required by Colorado insurance laws.

Recommendation Number 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-4-708 and 10-3-1104, C.R.S., and Colorado Insurance Regulation 5-2-8. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has reviewed its procedures for processing PIP claims and implemented necessary changes to ensure compliance with Colorado insurance laws.

Issue C: Failure, in some cases, to pay title and transfer fees on total loss claims.

Section 10-4-639, C.R.S., Claims practices for property damage, states in part:

(1) An insurer shall pay title fees, sales tax, and any other transfer or registration fee associated with the total loss of a motor vehicle.

During the review of total loss claim payments it was noted that in some cases, the Company did not include the payment of title and transfer fees as required by Colorado insurance law.

The following chart illustrates the significance of error versus the population and sample examined:

Private Passenger Automobile Total Loss Claims

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,626	50	14	28%

An examination of fifty (50) total loss automobile claim files, representing two percent (2%) of all total loss claim files handled by the Company during the examination period, showed fourteen (14) exceptions (28% of the sample) wherein the Company did not pay the title and transfer fee as required by Colorado insurance law.

Recommendation Number 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-4-639, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has corrected the non payment of title and transfer fees on total loss claims, and implemented necessary procedural changes in order to ensure compliance with Colorado insurance law.

Summary of Issues and Recommendations

AMERICAN FAMILY MUTUAL INSURANCE COMPANY

ISSUE	RECOMMENDATION NUMBER	PAGE
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